FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045757

Facility Name: Montebello HealthCare Center

Address: 16th & Keokuk (Number) Hamilton (City) 62341 (Zip Code)

County: Hancock

Telephone Number: 281-847-3931 **Fax #** 281-847-2049

IDPA ID Number: 75-2080781001

Date of Initial License for Current Owners: 08/01/1986

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[x]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[X]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Sherry L DeBons **Telephone Number:** (832) 467-6323

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Linda Holtzscheiter
(Title) Reimbursement Manager

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Montebello HealthCare Center # 0045757 Report Period Beginning: 1/1/2003 Ending: ########

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	139	Skilled (SNF)	139	50,735	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	139	TOTALS	139	50,735	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,647	454	3,302	5,403	8
9	SNF/PED					9
10	ICF	16,922	4,500	99	21,521	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,569	4,954	3,401	26,924	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 53.07%

D. How many bed-hold days during this year were paid by Public Aid?
none (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 06/01/1993

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 06/01/1993 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 139 and days of care provided 3,302

Medicare Intermediary Mutual Omaha

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Montebello HealthCare Center # 0045757 Report Period Beginning: 01/01/2003 Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	112,010	9,008	7,631	128,649		128,649		128,649			1
2	Food Purchase		114,690		114,690		114,690		114,690			2
3	Housekeeping	81,188	8,682		89,870		89,870		89,870			3
4	Laundry	23,068	12,755		35,823		35,823		35,823			4
5	Heat and Other Utilities			104,182	104,182		104,182	28	104,210			5
6	Maintenance	23,381	22,809	11,931	58,121	(931)	57,190	175	57,365			6
7	Other (specify):* Waste/Garbage -See pg 3.1			9,150	9,150		9,150		9,150			7
8	TOTAL General Services	239,647	167,944	132,894	540,485	(931)	539,554	203	539,757			8
	B. Health Care and Programs											
9	Medical Director			6,600	6,600		6,600		6,600			9
10	Nursing and Medical Records	940,353	59,784	30,903	1,031,040		1,031,040	12,841	1,043,881			10
10a	Therapy	142,333	2,753	9,460	154,546		154,546		154,546			10a
11	Activities	36,404	3,574	2,961	42,939	6,268	49,207		49,207			11
12	Social Services	38,115		3,342	41,457		41,457		41,457			12
13	Nurse Aide Training	5,887			5,887		5,887		5,887			13
14	Program Transportation	20,895		34	20,929	(20,895)	34		34			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,183,987	66,111	53,300	1,303,398	(14,627)	1,288,771	12,841	1,301,612			16
	C. General Administration											
17	Administrative	59,169			59,169		59,169		59,169			17
18	Directors Fees											18
19	Professional Services			384	384		384		384			19
20	Dues, Fees, Subscriptions & Promotions			17,311	17,311		17,311	(3,314)	13,997			20
21	Clerical & General Office Expenses	82,582	5,892	188,839	277,313		277,313	(9,895)	267,418			21
22	Employee Benefits & Payroll Taxes			328,589	328,589		328,589		328,589			22
23	Inservice Training & Education											23
24	Travel and Seminar			12,083	12,083		12,083	8,861	20,944			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			103,832	103,832		103,832	(12,869)	90,963			26
27	Other (specify):*											27
28	TOTAL General Administration	141,751	5,892	651,038	798,681		798,681	(17,217)	781,464			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,565,385	239,947	837,232	2,642,564	(15,558)	2,627,006	(4,173)	2,622,833			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Montebello HealthCare Center #0045757 Report Period Beginning: 01/01/2003 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			154,875	154,875		154,875	23,605	178,480			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(164)	(164)		(164)	164				32
33	Real Estate Taxes			53,255	53,255		53,255	(524)	52,731			33
34	Rent-Facility & Grounds							1,557	1,557			34
35	Rent-Equipment & Vehicles			5,939	5,939	(4,157)	1,782	1,076	2,858			35
36	Other (specify):* Home office							9,442	9,442			36
37	TOTAL Ownership			213,905	213,905	(4,157)	209,748	35,320	245,068			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					19,715	19,715	(19,715)				38
39	Ancillary Service Centers		48,717	1,190	49,907		49,907	12,119	62,026			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			76,103	76,103		76,103		76,103			42
43	Other (specify):*		926	6,882	7,808		7,808		7,808			43
44	TOTAL Special Cost Centers		49,643	84,175	133,818	19,715	153,533	(7,596)	145,937			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,565,385	289,590	1,135,312	2,990,287		2,990,287	23,551	3,013,838			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Montebello HealthCare Center # 0045757 Report Period Beginning: 01/01/2003 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals		22		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	164	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	7,219	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(168,527)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (161,144)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	184,695		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 184,695		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 23,551		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.	x		$ 19,715	38	38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 19,715		47

STATE OF ILLINOIS

Montebello HealthCare Center

ID# 0045757

Report Period Beginning: 01/01/2003

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Sales Taxes	$ (211)	21	1
2	Small Balance Adjustment	(0)	21	2
3	Memorium/ Benevolance	0	21	3
4	Depreciation Reconciliation	23,605	30	4
5	Activities Program Receipts	0	11	5
6	Property taxes -adjust to actual	(724)	33	6
7	Professional liability Insurance	(13,267)	26	7
8	Barber & beauty	0	40	8
9	Public Relations Expenses	0	20	9
10	Non Allowable Advertising	(4,079)	20	10
11	Entertaiment	(227)	24	11
12	Fresh Start	0	36	12
13	Civic Dues	(172)	20	13
14	Penalities	0	21	14
15	Vending reciepts	(1,177)	21	15
16	Misc Reciepts	(4,136)	21	16
17	Marketing Wages	0	21	17
18	Marketing Bonus Accrual	(1,146)	21	18
19	Marketing Holiday	0	21	19
20	Maketing Sick	0	21	20
21	Marketing Vacation	0	21	21
22	Marketing Overtime	0	21	22
23	Marketing Non Worked Wages	0	21	23
24	Donations/ Contributions	0	21	24
25	Legal Fees - Bankrupcty	0	21	25
26	Legal Structure Management Fees	(147,108)	21	26
27	Disallow Van Driver Wages Medical Transport	(14,627)	38	27
28	Undocumenated Travel per log	(2,187)	24	28
29				29
30	**Asset < $500 Asset # 5051**	307	21	30
31	**Asset < $500 Asset # 5058**	220.6	21	31
32	**Asset < $500 Asset # 5060**	632.94	21	32
33	**Asset < $500 Asset # 5061**	855.97	21	33
34				34
35	Disallow 70% of Repairs	-931	38	35
36	Disallow 70% of Lease of Van	-4157	38	36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(168,527)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Montebello HealthCare Center # 0045757 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	28	0	0	0	0	0	0	0	0	0	28	5
6	Maintenance	0	175	0	0	0	0	0	0	0	0	0	175	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	203	0	0	0	0	0	0	0	0	0	203	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	12,841	0	0	0	0	0	0	0	0	0	12,841	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	12,841	0	0	0	0	0	0	0	0	0	12,841	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(4,251)	937	0	0	0	0	0	0	0	0	0	(3,314)	20
21	Clerical & General Office Expenses	(144,542)	134,647	0	0	0	0	0	0	0	0	0	(9,895)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,414)	11,275	0	0	0	0	0	0	0	0	0	8,861	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(13,267)	398	0	0	0	0	0	0	0	0	0	(12,869)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(164,474)	147,257	0	0	0	0	0	0	0	0	0	(17,217)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(164,474)	160,301	0	0	0	0	0	0	0	0	0	(4,173)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Montebello HealthCare Center # 0045757 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	23,605	0	0	0	0	0	0	0	0	0	0	23,605	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	164	0	0	0	0	0	0	0	0	0	0	164	32
33	Real Estate Taxes	(724)	200	0	0	0	0	0	0	0	0	0	(524)	33
34	Rent-Facility & Grounds	0	1,557	0	0	0	0	0	0	0	0	0	1,557	34
35	Rent-Equipment & Vehicles	0	1,076	0	0	0	0	0	0	0	0	0	1,076	35
36	Other (specify):*	0	9,442	0	0	0	0	0	0	0	0	0	9,442	36
37	**TOTAL Ownership**	23,045	12,275	0	0	0	0	0	0	0	0	0	35,320	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	(19,715)	0	0	0	0	0	0	0	0	0	0	(19,715)	38
39	Ancillary Service Centers	0	12,119	0	0	0	0	0	0	0	0	0	12,119	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(19,715)	12,119	0	0	0	0	0	0	0	0	0	(7,596)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(161,144)	184,695	0	0	0	0	0	0	0	0	0	23,551	45

Facility Name & ID Number Montebello HealthCare Center # 0045757 Report Period Beginning: 01/01/2003 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mariner Health Care	100	See Attachment page 6.1		Mariner Health Care	Atlanta, GA	Management

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Mariner Health Care	100.00%	$ 28	$ 28	1
2	V	6	Repair & Maintenance		Mariner Health Care	100.00%	175	175	2
3	V	39	Professional Services		Mariner Health Care	100.00%	12,119	12,119	3
4	V	20	Fees, Subscriptions, Promotions		Mariner Health Care	100.00%	937	937	4
5	V	10	Nursing & Medical Records		Mariner Health Care	100.00%	12,841	12,841	5
6	V	21	Clerical & General Office Exp		Mariner Health Care	100.00%	134,647	134,647	6
7	V	24	Travel & Seminar		Mariner Health Care	100.00%	11,275	11,275	7
8	V	26	Insurance Premium		Mariner Health Care	100.00%	292	292	8
9	V	36	Depreciation		Mariner Health Care	100.00%	9,442	9,442	9
10	V	33	Taxes - Property		Mariner Health Care	100.00%	200	200	10
11	V	35	Rental & Leasing		Mariner Health Care	100.00%	1,076	1,076	11
12	V	34	Leasse Expense		Mariner Health Care	100.00%	1,557	1,557	12
13	V	26	Property Insurance		Mariner Health Care	100.00%	106	106	13
14	Total			$			$ 184,695	$ * 184,695	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Montebello HealthCare Center # 0045757 Report Period Beginning: 01/01/2003 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2	N/A										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Montebello HealthCare Center # 0045757 Report Period Beginning: 01/01/2003 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Mariner Health Care
Street Address: One Ravine Dr. Suite 1500
City / State / Zip Code: Atlanta, GA 30346
Phone Number: ((770) 379-8203
Fax Number: ((770) 399-1971

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities				$ 28	$		$ 28	1
2	6	Repair & Maintenance				175			175	2
3	39	Professional Services				12,119			12,119	3
4	20	Fees, Subscriptions, Promotions				937			937	4
5	10	Nursing & Medical Records				12,841			12,841	5
6	21	Clerical & General Office Exp				134,647			134,647	6
7	24	Travel & Seminar				11,275			11,275	7
8	26	Insurance Premium				292			292	8
9	36	Depreciation				9,442			9,442	9
10	33	Taxes - Property				200			200	10
11	35	Rental & Leasing				1,076			1,076	11
12	34	Leasse Expense				1,557			1,557	12
13	26	Property Insurance								13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 184,589	$		$ 184,589	25

Facility Name & ID Number Montebello HealthCare Center # 0045757 Report Period Beginning: 01/01/2003 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Montebello HealthCare Center # 0045757 Report Period Beginning: 01/01/2003 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 51,464	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 52,531	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,067	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 52,188	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 53,255	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	55,224	8
	1999	52,420	9
	2000	45,885	10
	2001	47,957	11
	2002	52,531	12

#4… G/L accrual for Property taxes

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Montebello HealthCare Cente COUNTY Hancock

FACILITY IDPH LICENSE NUMBER 0045757

CONTACT PERSON REGARDING THIS REPORT Sherry DeBons

TELEPHONE (832) 467-6323 FAX #: (832) 467-6336

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200.

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-29-999-119	Lot B Sub (EX 2A SE Cor & 377)	$ 26,265.53	$ 26,265.53
2.	11-29-999-119	Lot B Sub (EX 2A SE Cor & 377)	$ 26,265.53	$ 26,265.53
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 52,531.06	$ 52,531.06

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill whic is normally paid during 2003.

Facility Name & ID Number Montebello HealthCare Center # 0045757 Report Period Beginning: 01/01/2003 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 25,581 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	305,550	1993	$ 43,747	1
2					2
3	TOTALS	305,550		$ 43,747	3

Facility Name & ID Number Montebello HealthCare Center # 0045757 Report Period Beginning: 01/01/2003 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	139		1993	1974	$ 2,576,687	$ 122,699	21	$ 122,699	$	$ 756,646	4
5					46,664	2,333	20	2,333		27,998	5
6											6
7											7
8											8
	Improvement Type**										
9	Interior Building Improvements			1995	8,889	444	20	444		4,772	9
10	A/C Units			1996	2,775	139	20	139		1,170	10
11	Sprinkle Guard System			1996	887	44	20	44		372	11
12	Sprinkler Repair			1997	2,239	112	20	112		877	12
13	Sprinkler Repair			1997	2,317	116	20	116		795	13
14	Carpet in Lobby			1997	1,890	95	20	95		595	14
15	Nurses Station			1997	2,363	118	20	118		904	15
16	A/C Systems			1997	8,325	416	20	416		3,101	16
17	Nurses Station			1997	2,613	131	20	131		966	17
18	A/C Systems			1997	2,969	148	20	148		986	18
19	Light Fixtures			1997	1,002	50	20	50		333	19
20	Sprinkler Repair			1997	797	40	20	40		316	20
21	2: Exterior Signs #73			1998	663	5	12	5		308	21
22	Heating, Ventilation & A/C			1998	2,643	264	10	264		1,454	22
23	Rplc 6: 18K BTU Heating, Ventilation & A/C #77			1998	4,070	407	10	407		2,170	23
24	2: 60 K BTU Kitchen Heating, Ventilation & A/C #78			1998	6,800	407	10	407		3,627	24
25	Phone System #72			1998	1,338	134	10	134		803	25
26	Nurses Station #71			1998	1,925	128	20	128		770	26
27	Adjustment 1998			1998		(35)			35		27
28	Water Heater #80 & 81 & 82			1999	3,092	309	10	309		1,339	28
29	Water Pipe Hook-up #83 & 84			1999	256	26	10	26		110	29
30	Generator 100 AMP XFER Switch #93			2001	5,137	257	20	257		771	30
31	3: Door Relay Instl #94			2001	912	91	10	91		258	31
32	2: W/G Monitor Digat Reset #95			2001	1,892	189	10	189		536	32
33	Use Tax 2: W/G Montor Digat #96			2001	8,191	819	10	819		2,321	33
34	Kohler Sink W/ Sink Rims #97			2001	592	30	20	30		84	34
35	Use Tax:Kohler Sink W/ Sink Rims #98			2001	34	2	20	2		4	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Montebello HealthCare Center # 0045757 Report Period Beginning: 01/01/2003 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Royal 3.5 Gal Water Sver #99	2001	$ 325	$ 17	20	$ 17	$	$ 30	37
38	Use Tax: Royal 3.5 Gal Water Sver #100	2001	20	1	20	1		2	38
39	Wanderguard & Lock System Instl #102	2001	8,360	836	10	836		1,533	39
40	Air Handler & Coil Instl, Kitchen #105	2001	915	46	20	46		76	40
41	2:Push-Button & Digital reset #106	2001	822	82	10	82		137	41
42	Instl 5Ton A./C Unit Kitchen #107	2001	1,475	148	10	148		221	42
43	Instl Charge W/G System #110	2001	325	33	10	33		43	43
44	E Elec Water Heater Instl #111	2001	3,275	327	10	327		436	44
45									45
46	DuKane Nurse Call system #5010	2002	17,665	1,767	10	1,767		2,797	46
47	DuKane Nurse Call system # 5011	2002	6,837	684	10	684		1,026	47
48	Service Call - Old Nurse Call System # 5022	2002	863	86	10	86		1,048	48
49	Nurse Call System # 5026	2002	17,748	1,775	10	1,775		2,366	49
50	Nurse Call System -Bal Due # 5026	2002	17,748	1,775	10	1,775		2,219	50
51	Instl Nurse Call System #5027	2002	2,532	253	10	253		316	51
52									52
53	New Nurse Call Station #5030	2003	4,720	511	10	511		511	53
54	Breaker Instl Range Hood #5032	2003	2,135	249	10	249		249	54
55	155: Brass Dry Pendants Instl #5035	2003	1,086	25	25	25		25	55
56	Carrier -RTU NW Wing #5042	2003	7,548	377	10	377		377	56
57	Add sprinkler Head Stairs # 5047	2003	760	10	25	10		10	57
58	Rplc Roof UltraPlus (29% Dwn) # 5048	2003	43,215	1,801	10	1,801		1,801	58
59	CREDIT Maglock Sngl Door (#15580) #5049	2003	(691)	(184)	10	(184)		(184)	59
60	Wanderguard Instl #5050	2003	338	90	10	90		90	60
61	7: Verticle Blinds #5052	2003	840	70	3	70		70	61
62	7: Rodpocket Draps, 7 Rods # 5053	2003	869	58	3	58		58	62
63	Replc Roof #5054	2003	86,443	2,161	10	2,161		2,161	63
64	Blinds 30 Resident Rooms # 5055	2003	1,371	114	3	114		114	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,925,504	$ 143,029		$ 143,064	$ 35	$ 831,920	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Montebello HealthCare Center # 0045757 Report Period Beginning: 01/01/2003 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 893,563	$ 33,521	$ 33,521	$		$ 257,037	71
72	Current Year Purchases	27,003	1,895	1,895			1,895	72
73	Fully Depreciated Assets	(482,599)						73
74								74
75	TOTALS	$ 437,967	$ 35,416	$ 35,416	$		$ 258,932	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,407,219	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 178,445	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 178,480	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 35	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,090,852	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	O/H Allocation 06/01/1996	$ 636	$ 32	$ 242	86
87	O/H Allocation 12/01/1996	1,136	57	403	87
88	O/H Allocation 08/01/1997	2,127	106	680	88
89	O/H Allocation 10/01/1997	360	18	112	89
90					90
91	TOTALS	$ 4,259	$ 213	$ 1,437	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Montebello HealthCare Center # 0045757 Report Period Beginning: 01/01/2003 Ending: 12/31/03

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: none

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [x] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO

16. Rental Amount for movable equipment: $ 5,146 Description: Ice Machine, Cooler, Diswasher, Copies & Postage Machine
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Activities & Patient	1999 Ford - Van E350	$ Var	$ 5,939	17
18	Transporation				18
19					19
20					20
21	TOTAL		$	$ 5,939	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Montebello HealthCare Center # 0045757 Report Period Beginning: 01/01/2003 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Montebello HealthCare Center # 0045757 Report Period Beginning: 01/01/2003 Ending: 12/31/03

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a -03	2197 hrs	$ 45,790		$	$	2,197	$ 45,790	1
2	Licensed Speech and Language Development Therapist	10a -03	458 hrs	22,337				458	22,337	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a -03	3702 hrs	74,206			174	3,702	74,380	4
5	Physician Care	39 - 03	visits							5
6	Dental Care	39 - 03	visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 03	# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)	39 - 03	hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$ 142,333		$	$ 174	6,357	$ 142,507	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Montebello HealthCare Center # 0045757 Report Period Beginning: 01/01/2003 Ending: 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,450	$	1
2	Cash-Patient Deposits	5,024		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	221,479		3
4	Supply Inventory (priced at)	13,670		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See attachment Schd 17.1			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 241,623	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	70,000		13
14	Buildings, at Historical Cost	2,257,943		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	231,848		16
17	Accumulated Depreciation (book methods)	(273,554)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Rounding	1		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,286,238	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,527,861	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 45,819	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	(1,349)		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	114,642		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,190		31
32	Accrued Real Estate Taxes(Sch.IX-B)	52,188		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attachment Schd 17.1	31,633		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 246,123	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See attachment Schd 17.1	(1,116,238)		43
44	Rounding	(1)		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ (1,116,239)	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ (870,116)	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,397,977	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,527,861	$	48

*(See instructions.)

Facility Name & ID Number Montebello HealthCare Center # 0045757 Report Period Beginning: 01/01/2003 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,798,038	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,798,038	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(34,061)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (34,061)	17
	B. Transfers (Itemize):		
18	**Fresh Start Acctg Due to Bankrupty**		18
19	**Move CY to PY R/E**	(366,000)	19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (366,000)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,397,977	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Montebello HealthCare Center # 0045757 Report Period Beginning: 01/01/2003 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,585,166	1
2	Discounts and Allowances for all Levels	(1,405,328)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,179,838	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	513,515	6
7	Oxygen	3,285	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 516,800	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	24	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	87,119	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	40,354	19
20	Radiology and X-Ray		20
21	Other Medical Services	128,820	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 256,317	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc & General Revenue	2,095	28
28a	Misc Receipts	1,177	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,272	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,956,227	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	540,485	31
32	Health Care	1,303,398	32
33	General Administration	798,681	33
	B. Capital Expense		
34	Ownership	213,905	34
	C. Ancillary Expense		
35	Special Cost Centers	57,715	35
36	Provider Participation Fee	76,103	36
	D. Other Expenses (specify):		
37	rounding	1	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,990,288	40
41	**Income before Income Taxes (line 30 minus line 40)****	(34,061)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (34,061)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Montebello HealthCare Center # 0045757 Report Period Beginning: 01/01/2003 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,238	2,479	$ 57,581	$ 23.23	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,668	2,955	55,794	18.88	3
4	Licensed Practical Nurses	17,467	19,343	273,112	14.12	4
5	Nurse Aides & Orderlies	49,247	54,535	482,144	8.84	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	2,249	2,482	73,129	29.46	7
8	Rehab/Therapy Aides	3,513	3,876	69,204	17.85	8
9	Activity Director	1,853	2,002	23,126	11.55	9
10	Activity Assistants	1,990	2,150	13,279	6.18	10
11	Social Service Workers	3,099	3,466	38,115	11.00	11
12	Dietician					12
13	Food Service Supervisor	1,649	1,773	18,791	10.60	13
14	Head Cook	3,759	4,043	34,303	8.48	14
15	Cook Helpers/Assistants	8,084	8,694	58,916	6.78	15
16	Dishwashers					16
17	Maintenance Workers	2,058	2,209	23,381	10.58	17
18	Housekeepers	9,545	10,325	81,188	7.86	18
19	Laundry	3,574	3,956	23,068	5.83	19
20	Administrator	1,950	2,109	77,470	36.73	20
21	Assistant Administrator					21
22	Other Administrative	1,923	2,080	35,309	16.98	22
23	Office Manager					23
24	Clerical	2,398	2,594	27,825	10.73	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Ca Care & Case Mgt	3,990	3,990	77,609	19.45	32
33	Other(specify) Mkting & transpor	1,753	1,865	22,041	11.82	33
34	TOTAL (lines 1 - 33)	125,007	136,926	$ 1,565,385 *	$ 11.43	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	160	$ 6,144	1 - 3	35
36	Medical Director	100	6,600	9 - 3	36
37	Medical Records Consultant				37
38	Nurse Consultant	2,945	134,760	10 - 7	38
39	Pharmacist Consultant	116	4,998	10 -3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	97	3,194	10a- 3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	86	2,790	10a- 3	43
44	Activity Consultant	54	2,961	11 - 3	44
45	Social Service Consultant	61	3,342	12 - 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	3,619	$ 164,789		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10 - 3	50
51	Licensed Practical Nurses		0	10 - 3	51
52	Nurse Aides		0	10 - 3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Montebello HealthCare Center # 0045757 Report Period Beginning: 01/01/2003 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
Rebecca Bliss	Adminstrator	100%	59,169
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 59,169

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
Legal	Legal fees	384
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 384

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 67,769
Unemployment Compensation Insurance	27,539
FICA Taxes	112,949
Employee Health Insurance	109,410
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
Pension / retirment	2,912
insurance Life	2,141
Other Benefits	5,869
Home Office Allocation	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 328,589

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,675
Health Care Worker Background Check	2,262
(Indicate # of checks performed)	
Other Licenses Fees	1,180
Dues	6,893
Less civil Dues	(172)
Home Office Allocation	937
Total Advertising	4,301
Less: Public Relations Expense	(0)
Non-allowable advertising	(4,079)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,997

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 3,197
In-State Travel	5,657
Home Office allocation	11,275
Seminar Expense	3,042
Entertainment Expense	(227)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 22,944

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Montebello HealthCare Center # 0045757 Report Period Beginning: 01/01/2003 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Montebello HealthCare Center # 0045757 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois HealthCare Association - $7,222.**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **18,581** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **none**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/a**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/a** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/a** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES

Operating Expense - Line 7	Amount
Infectious Waste Disposal <> Default <> Nursing Admin/Supv	3,639
Infectious Waste Disposal <> Default <> Physical Plant	0
Garbage Service<>Default<>Prod<>Physical Plant	5,511
Garbage Service <> Default <> Physical Plant	0
	9,150

Health Care Program - Line 15	Amount
N/A	
	0

General & Adminstrative - Line 27	Amount
N/A	
	0

Inservice Education - Line 23 Column 3 (over $2,000)	Amount
N/A	
	0

STATE OF ILLINOIS

Facility Name & ID Number Montebello HealthCare Center # 0045757 Ending: 12/31/03

Meals - adjustment

26,924	Days (Total Patient days)
3	Mult (3 meals a day)
80772	Sub total
0	meals to employess (reported by facility)
80772	Add Sub
114690	Divide -Pg 3, line 2, column 2
1.42	Cost per day

1.42	Cost per day
0	mult - meal to employees
0	= adjust for pg 2, line 2, column2

Sales Tax - adjustment

114,690	Total Food Cost (page 3,Line 2, col 3)
0.01	Mult
1146.9	Sub total
18.40%	Mult (Pvt pay div by total census)
211	= adjust for nonallowable sale tax for page 5A,

Reclassification V

Page 3 Line 6

Repair & Maint <> Vehicles<>Default<>Prod<	830010000003850	-931 Reclass From
1330 x 70% = 931)		
Page 4 line 38		931 Reclass to

Page 3 Line 14

Salaries <> Regular<>Driver<>Transport Non<>Emerg	700000750403850	(19,596) Reclass From
Salaries Overtime/Dbl Time<>Driver<>Transport Non<:	700500750403850	(47) Reclass From
Vacation Pay <> Earned Lve Acc.<>Default<>Prod<>T	730012000003850	(483) Reclass From
Holiday Pay <> Earned Lve Taken<>Default<>Prod<>1	730013000003850	(514) Reclass From
Sick Pay <> Earned Leave Taken<>Default<>Prod<>T	730031000003850	(256) Reclass From
(20,895 x 70% = 14,627) 70% is Medical 30% is activities		(20,896) total
Page 3 line 11		6,268 Reclass to
Page 4 line 38		14,627 Reclass to

Page 4 Line 35 Rent

Lease Exp <> Vehicles<>Default<>Prod<>Transport N	841005000003850	(4,157) Reclass From
(5,939 x 70% = 4157 lease for Medical)		
Page 4 line 38		4,157 Reclass to

STATE OF ILLINOIS

Facility Name & ID Number Montebello HealthCare Center # 0045757 Ending: 12/31/03

SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES

Ownership - Line 36	Amount
Fresh Start Acctg Adj <> Bankrupty Exp Acq <> Cost Non Overhead	0
	-

Ancillary Expenses - Line 43 -Column 2	Amount
Ancillary Cost of Goods Sold<>Default<>Prod<>Laboratory	0
	0

Ancillary Expenses - Line 43 -Column 3	Amount
Professional Services <> Nonchg<>Other Medical Professionals<>Labora	0
Professional Services <> Nonchg<>Other Medical Professionals<>X/Ray	0
Professional Services <> Nonchg<>Medical Director<>Laboratory	0
Professional Services <> Nonchg<>Medical Director<>X/Ray	0
Professional Services <> Nonchg<>Other Medical Professionals<>Labora	6,496
Professional Services <> Nonchg<>Other Medical Professionals<>X/Ray	386
Ancillary Cost of Goods Sold<>Default<>Prod<>Laboratory	926
	7,808

Related Illinois Nursing Homes as of 12/31/2003

Group Name	Related Illinois Nursing Homes	Illinois Facility Number
Mariner Health Care	LaSalle Health & Rehabilitation Center	0037671
	Litchfield HealthCare Center	0037689
	Montebello Healthcare Center	0031468
	Nature Trail HealthCare Center	0039586
	Odin HealthCare Center	0039503
	Mariner Health of Westchester	0042374

SUPPLEMENATAL SCHEDULE OF ASSETS & LIABILITIES

OTHER CURRENT ASSETS:	AMOUNT
Total	0
Reconcile with schedule XV, line 9:	0
Difference	0

OTHER CURRENT LIABILITIES:	AMOUNT
Misc Dedctns - Employee <> Other Decductions <> Default	(3,629)
Misc Dedctns - Employee <> Union Dues <> Default	
Accruals - Insurance <> Accrue HMO Ins <> Default	
Accruals - Insurance <> Self Funded Ins Accr <> Default	(26,595)
Accruals - Insurance <> Basic Life <> Default	(400)
Accruals - Insurance <> Lt Dsblty <> Default	(77)
Accruals - Insurance <> Dental Ins <> Default	
Accruals - Insurance <> Executive Supp Life <> Default	(177)
Accruals - Insurance <> Short Term Disability <> Default	(464)
Accruals - Insurance <> Dependent Life <> Default-Dept	(63)
Accruals - Insurance <> Accidental Death Dismemberment <> Default-Dept	(28)
Accruals - Insurance <> NES Insurance <> Default-Dept	(200)
L/T Debt - Current Portion <> Current Portion <> Default	
Total	(31,633)
Reconcile with schedule XV, line 36:	(31,633)
Difference	-

OTHER NON-CURRENT ASSETS:	
Excess Reorganized Value <>Excess Reorg Value <> Default	-
Other Assets <> Rfndable Deposits-Non Int Brg <> Default	-
Total	-
Reconcile with schedule XV, line 23:	0
Difference	-

OTHER NON-CURRENT LIABILITIES::	
Intercompany - Revolver <> Default <> Default	1,116,238
N/P - Mortgage <> Mortgages <> Default	
Total	1,116,238
Reconcile with schedule XV, line 43:	1,116,238
Difference	0

SUPPLEMENATAL SCHEDULE OF ASSETS & LIABILITIES

DESCRIPTION	AMOUNT
Personal Purchase Receipts <> Default <> Vending	0
Miscellaneous Receipts<>Default<>Prod<>Vending	
Miscellaneous Receipts<>Default<>Prod<>Administrative	(1,435)
General Rental Receipts<>Default<>Prod<>Administrative	(660)

Total	(2,095)	Difference
Reconcile with schedule XVII, line 28:	(2,095)	0

DESCRIPTIONS	
Personal Purchase Receipts <> Default <> Patient Personal Purchase	-
Personal Purchase Receipts <> Default <> Miscellaneous Receipts	-
Personal Purchase Expense <> Default <> Patient Personal Purchase	-
Miscellaneous Receipts <> Default-Prod <> Other Misc Rev	-
Activity Programs Receipts <> Default <> Other Misc Rev	-
Miscellaneous Receipts<>Default<>Prod<>Activities	
Miscellaneous Receipts<>Default<>Prod<>Vending	(1,177)

Total	(1,177)	Difference
Reconcile with schedule XVII, line 28a:	(1,177)	-